Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States

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Hematologic Toxicity

A complete blood count and differential should be performed on newborns exposed to HIV before initiation of infant antiretroviral (ARV) drug prophylaxis. Decisions about the timing of hematologic monitoring of infants after birth depend on a number of factors, including baseline hematologic values, gestational age at birth, clinical condition of the infant, which ARV drugs are being administered, receipt of other ARV drugs and concomitant medications, and maternal antepartum therapy. Hemoglobin and neutrophil counts should be remeasured 4 weeks after initiation of prophylaxis for infants who receive combination zidovudine/lamivudine-containing ARV prophylaxis regimens.

In utero exposure to maternal combination ARV drug regimens may be associated with more anemia and/or neutropenia compared with that seen in infants exposed to zidovudine alone. In PACTG 316, where 77% of mothers received antenatal combination therapy, significant Grade 3 or higher anemia was noted in 13% and neutropenia in 12% of infants, respectively. Some experts recommend more intensive monitoring of hematologic and serum chemistry and liver function assays at birth and when diagnostic HIV PCR tests are obtained in infants exposed to combination ARV drug regimens in utero or during the neonatal period.
Data are limited on infants receiving zidovudine in combination with other ARV drugs for prophylaxis. However, higher rates of hematologic toxicity have been observed in infants receiving zidovudine/lamivudine and other combination prophylactic regimens compared with those receiving zidovudine alone or zidovudine plus nevirapine. Hemoglobin levels and neutrophil counts, therefore, should be remeasured 4 weeks after initiation of prophylaxis and/or at the time that diagnostic HIV PCR testing is done in infants who receive combination zidovudine/lamivudine-containing ARV prophylaxis regimens.8

If hematologic abnormalities are found, decisions on whether to continue infant ARV prophylaxis need to be individualized. Considerations include the extent of the abnormality, whether related symptoms are present, duration of infant prophylaxis, and risk of HIV infection (as assessed by maternal history of ARV prophylaxis, viral load near delivery, and mode of delivery). A 4-week zidovudine regimen has been reported to result in earlier recovery from anemia in otherwise healthy infants compared with the 6-week zidovudine regimen.9 A 4-week (instead of 6-week) zidovudine neonatal chemoprophylaxis regimen is recommended when a mother has received standard antiretroviral therapy (ART) during pregnancy with consistent viral suppression and no concerns related to maternal adherence; the shorter regimen will mitigate the risk of anemia in such infants, who are at low risk of acquiring HIV (see Antiretroviral Management of Newborns).10,11

**Hyperlactatemia**

Hyperlactatemia has been reported in infants with in utero exposure to ARV drugs, but it appears to be transient and, in most cases, asymptomatic.12,13 Routine measurement of serum lactate is not recommended in asymptomatic neonates to assess for potential mitochondrial toxicity because the clinical relevance is unknown and the predictive value for toxicity appears poor.12,13 Serum lactate measurement should be considered, however, for infants who develop severe clinical symptoms of unknown etiology, particularly neurologic symptoms. In infants with symptoms, if levels are significantly abnormal (i.e., >5 mmol/L), ARV prophylaxis should be discontinued and an expert in pediatric HIV infection consulted regarding alternate prophylaxis.

**Prophylaxis Against Pneumocystis jirovecii Pneumonia**

To prevent *Pneumocystis jirovecii* pneumonia, all infants born to women with HIV should begin trimethoprim-sulfamethoxazole (TMP-SMX) prophylaxis at age 4 to 6 weeks, after completion of the infant ARV prophylaxis regimen, unless there is adequate virologic test information to presumptively exclude HIV infection (see the Pediatric OI Guidelines).14

**HIV Testing of the Infant**

All infants perinatally exposed to HIV require virologic HIV testing to diagnose HIV or determine that they have not acquired HIV. For a detailed discussion, including types of tests and recommended HIV testing schedule, see Diagnosis of HIV Infection in Infants and Children.

**Postnatal Management**

Following birth, infants exposed to HIV should have a detailed physical examination, and a thorough maternal history should be obtained. Mothers living with HIV may be coinfected with other pathogens that can be transmitted from mother to child, such as cytomegalovirus, Zika virus, herpes simplex virus, hepatitis B, hepatitis C, syphilis, toxoplasmosis, or tuberculosis. Infants born to mothers with such coinfections should undergo appropriate evaluation, as indicated by maternal CD4 T lymphocyte count and evidence of disease activity, to exclude the possibility of transmission of additional infectious agents. The routine primary immunization schedule should be followed for exposed infants born to mothers with HIV. Modifications in the schedule may be required for infants with known HIV (see the Pediatric OI Guidelines for more information).

No evidence is available to enable the Panel on Treatment of Pregnant Women with HIV Infection and Prevention of Perinatal Transmission to assess whether any changes in routine bathing practices, or timing of
Infant Feeding Practices and Risk of HIV Transmission

In the United States, where safe infant feeding alternatives are available, it is recommended that women with HIV not breastfeed their infants. Maternal receipt of ART is likely to reduce free virus in breast milk, but the presence of cell-associated virus (intracellular HIV DNA) remains unaffected and may continue to pose a transmission risk. However, clinicians should be aware that some women may face considerable social, familial, and personal pressures to breastfeed despite this recommendation. It is important to address possible barriers to formula feeding beginning as early as possible in the antenatal period (see Postpartum Follow Up).

Some HIV transmission events in later infancy are thought to have resulted from infants being fed solid food that has been premasticated (prechewed or prewarmed) by caregivers with HIV. Phylogenetic comparisons of virus from cases and suspected sources and supporting clinical history and investigations identified the practice of feeding premasticated foods to infants as a potential risk factor for HIV transmission. Health care providers should routinely inquire about premastication, instruct caregivers living with HIV against this feeding practice, and advise on safer feeding options.

References


